Utah Department of Health
Office of Primary Care and Rural Health
P.O. Box 142005
Salt Lake City, Utah 84114-2005
(801) 538-6113 FAX: (801) 538-6387
Web Site: http://health.utah.gov/primarycare/

ATTENTION:
Site Applications Are Reviewed for Designation at Least Once Each Year.

SITE APPLICATION FORM FOR THE UTAH HEALTH CARE WORKFORCE FINANCIAL ASSISTANCE PROGRAM

REQUIRED INFORMATION

To become an eligible site for the Utah Health Care Workforce Financial Assistance Program (HCWFAP), the applicant organization/agency *must* complete the **entire** "Site Application Form" and include all requested attachments. **All of the required information and documentation must be submitted in a single package.** Submitted "Site Application Forms" must not be bound or stapled. *One application must be submitted for **all** health care professionals* (clinicians) *requested.* The information contained in the Site Application Form will be used to assist in determining eligibility and prioritization of sites. Section A through G are not scored, but answers are required. PLEASE NOTE: If a response is attached, it *must* be noted where the response to the question is, i.e., Question H.1. **Description of the service area.** Response: See Attachment B, Number 4.

"Preference may be given to site applicants (licensed facilities) with a minimum average annual client capacity of ten (10)."

A. _____
Name of Practice Site

_____
Street Address

_____ _____
Mailing Address (if different than Street Address) County Practice Site Located

_____ _____
City Zip Code

( ) _____ ( ) _____
Telephone Number Fax Number

B. _____
Name of Sponsoring Organization (If different than Practice Site)

_____
Name and Title of Sponsoring Administrative Official

X _____ _____
Signature of Sponsoring Administrative Official *Date*

_____
Street Address

_____
Mailing Address (if different than Street Address)

_____ _____
City Zip Code

( ) _____ ( ) _____
Telephone Number Fax Number

_____ http://
Email Address Web Site Address

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C. Check Only One Below:
- ☐ Public
- ☐ Private Non-Profit
- ☐ Private For-Profit

Check Only One As Follows:
- ☐ Group Practice (Office)
- ☐ Hospital
- ☐ Institution
- ☐ Long-Term Care Facility
- ☐ Private Practice (Office)
- ☐ University
- ☐ Other (please explain):_____

D. **Health Care Professionals covered by the HCWFAP**.

1. Please note that ***only*** *the following* fully-licensed health care professionals are covered by the HCWFAP:

Dentists:	Mental Health Therapists:	Staff Nurses:
D.D.S.	Clinical Psychologist	Licensed Practical Nurse
D.M.D.	Licensed Clinical Social Worker	Associate Degree Nurse (R.N. ONLY)
	Licensed Professional Counselor	Bachelor Degree Nurse
	Marriage and Family Therapist	Master Degree Nurse

Physicians:	Midlevel Practitioners:
D.O.	Certified Nurse Midwife
M.D.	Nurse Practitioner
	Physician Assistants-Certified
	Certified Registered Nurse Anesthetist

2. Preference may be given to "primary care" health care professionals. Other specialties may be considered by the HCWFAP based on funding availability.

3. Nurse Educators may also be considered by the HCWFAP. Utah Schools of Nursing must use the required "Site Application for Utah Nursing Schools."

E. **Discipline and Specialty of the Health Care Professional requested**.
Note: If you are requesting other than a primary care health care professional, additional justification may be required.

1. Describe the discipline and speciality (if any) of the health care professional you are requesting. (For example, a physician who specializes in pediatric outpatient care, a dentist providing general dental care, an Associate Degree Nurse (R.N.) providing general client care.) [no points, but answer required]

X *NOTE*: Sites requesting physician assistants ***must*** include the name of the supervising physician, and supervising physician's specialty, who will be supervising requested health care professional; and whether or not the supervising physician is full-time at the site. Sites requesting staff nurses ***must*** include the name of the nursing director who will be supervising requested health care professional; and whether or not the nursing director is full-time at the site. [no points, but answer required]

2. Include the percent and/or FTE for the position(s) requested, **and** the number of hours per week required for that percent/FTE. (Such as, 1 FTE or 100% general dentist at 40 hours per week; .5 FTE or 50% certified physician assistant at 20 hours per week; 1 FTE or 100% bachelor's degree nurse (R.N.) at 32 hours per week.) [no points, but answer required]

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F. **Special Non-clinical Qualifications of the Health Care Professional Requested**. Describe any special non-clinical qualifications (if any) the health care professional may need to serve the needs at your site (such as other languages, cultural experiences, specialty training). Please write "NA" if not applicable. [no points, but answer required]

G. **Health Care Professional Match**. Do you currently have a health care professional you would like matched with your site, if your site application is approved? If so, please provide us with the name(s) and discipline(s) (such as, Florence Nightingale, C.N.M., Bacchus, Utah; Benjamin Spock, M.D., Family Practitioner, Peplin, Utah).

H. **Scored Section of Site Application**. *Responses are required for all questions.* Please write "NA" or detailed explanation to questions that are not applicable to your site.

1. **Description of the service area.** Describe the geographic area where the majority of the site's current service population reside (urban sites should use major street boundaries, if possible; and rural sites should include the names(s) of the county(ies) in their service area). **Please note**: A site is considered "Urban" if it is located in Davis, Salt Lake, Utah, or Weber counties.

2. **Describe the type and adequacy of your practice site for the requested health care professional**.

a) Describe the type of practice of the site, including all support services available. You must provide 1) the number of exam/office rooms per clinician by discipline, 2) number of support personnel to be hired or to be used by the requested health care professional, 3) handicapped accessibility, and 4) list any in-kind services where the requested health care professional described under item E would be expected to practice.

b) Describe the adequacy of the practice site. Does your site have the following (please check all that apply):

☐ Handicapped Accessibility	☐ Outreach Services	☐ WIC Services
☐ Health Education Services	☐ Sick Room	☐ X-ray Services
☐ Laboratory Services	☐ Waiting Room	

Other (please explain):_____

Does your site offer the following services (please check all that apply):

☐ Dental Care	☐ Medical Care	☐ Mental Health Care

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3. **Client encounters *at the site*.**

Total in the last 12 months	Number
Dental	
Medical, include C.N.M., N.P., and P.A.-C	
Mental Health	

4. **Special populations served** as percent of total client encounters provided to the service area by the site's current clinicians. Please note: Use "0" or NA for populations not served by site. In "Other" section, please **do not** use "*100% mentally ill clients*" or "*100% inmate populations*."

	Percent	Source of Data
AIDS/HIV cases	%	
Clients 17 years old and younger	%	
Clients 65 years old and older	%	
Ethnic/Minority populations **(Please describe)**	%	
Homeless	%	
Migrant/Seasonal Farmworkers	%	
Seasonal Population Variations	%	
Other *(for example, developmentally disabled, handicapped, etc.)* (**Please describe**)	%	

5. **Financial information on site.**

a) For the last year, provide the following information for the site for which the applicant is requesting approval:

Total charges	$
Contractual write-offs	$
Cost of unreimbursed care	$
Collections (*do not include contractual write-offs*)	$
Operating expenses	$
Subsidy from outside sources	$
Net profit/loss from operations	$

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b) For the last year, provide the **percent** of total encounters by payer source at the site for which the applicant is requesting approval:

CHIP	%
Medicaid	%
Medicare	%
No Insurance/Self Pay (Above 200% poverty level)	%
No Insurance/Self Pay (Below 200 % poverty level)	%
Primary Care Network	%
Other (**Please describe**)	%

c) Does your site use a sliding fee schedule? ☐ No ☐ Yes *Please attach a copy of your sliding fee schedule.*
If you *do not* use a sliding fee schedule, a detailed explanation of how care is provided to individuals "regardless of their ability to pay."

6. **Residence of clients** (as a percent of total encounters at the site):

Zip Code of Residence (List *ALL* Zip Codes, *Not a Range of Zip Codes*)	**Percent** (Do not use figures less than 5%)
	%
	%
	%
	%
	%
Unknown	%
Total (Total Does Not Need To Add to 100 percent)	%

7. Please provide the **current clinical staffing** at your site, that will be working with the health care professional requested? What is your site's **projected clinical staffing need** that will be working with the health care professional requested?

	Number of Dentists	**Number of Mental Health Therapists**	**Number of Midlevel Practitioners** (Advanced Practice Nurses and Physician Assistants)	**Number of Physicians**	**Number of Staff Nurses** (Licensed Practical Nurses and Registered Nurses)
Current Staffing					
Projected Staffing Need					
Projected Staffing: Funded But Unfilled					

8. **Source of funding**.

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a) What are the initial **sources of funding for the salary and benefits for the health care professional** described under item E? For the next five years, what types of financial support will be available and accessible to continue long-term employment?

b) *Please include a copy of the **initial type of contract or employment agreement that would be offered to the health care professional** described under item E.* Contracts should include malpractice insurance. If the health care professional requested does not have a contract or employment agreement, but will be an employee of the site - please include a copy of the benefits package that is offered to the employee including health insurance benefits, hours of paid vacation, hours of sick leave, continuing education leave offered, etc.

c) What are the **sources of financial support for operations including medical staff, administrative personnel, space, supplies, and equipment**?

d) *Include with site application packet* your organization's/agency's most recent audit report, and a written **recruitment and retention plan** that will be used by the applicant site.

9. **Next available facility.** If your site closed, *how long would it take* your clients to reach the next health care facility where they would receive services provided at your site? Please identify the name of that facility.

10. Person completing this application:

Name:_____

Title:_____

Email:_____ Telephone: (____)_____

X Signature:_____ Date:_____

12. Additional comments or information: ***A maximum limit of 2 pages for any comments or additional information.***

PLEASE RETURN COMPLETED SITE APPLICATION FORM, AND ATTACHMENTS, TO:
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CHECK LIST:

Have you included each of the following? If not, your application may be delayed or denied. *Please assure that each of the boxes below are checked and this Check List is returned with your completed site application.*

☐ Have all sections of the Site Application been completed? Sections "not applicable" to the site should have been marked "NA." If not, your site application may be delayed or denied.

☐ Has the Sponsoring Administrative Official of the Site signed on page 1 of 7? If not, application will be returned to site.

☐ E1. Did you provide the Discipline and Specialty of the Health Care professional being requested on page 2 of 7? If not, application will be returned to site.
☐ E2. If your site is requesting a physician assistant or staff nurses, you must include the name of the supervising physician or nursing director. Please assure that you have responded to all information listed in section E item 1. If not, application will be returned to site.
☐ E3. Did you include the percent time or FTE of the health care professional requested? If not, application will be returned to site.

☐ Have you included the name of a health care professional that you would like matched with your site? A response to this question will assist the HCWFAP in matching sites with health care professional applicants.

☐ Have you provided a description of the service area as listed under section H. item 1 on page 3 of 7? If not, application will be returned to site.

☐ 2a. Did you include a clear description of the type of your practice site to support the health care professional requested, as listed under section H. item 2.a)? If not, application will be returned to site.
☐ 2b. Did you check all application boxes in section H. item 2.b)?

☐ Have you responded to all questions under section H. item 4 on page 4 of 7? If not, application will be returned to site.

☐ Have you included a copy of your sliding fee schedule? If not, application may be delayed or denied.

☐ Have you responded to section H. item 5 on page 5 of 7 of application? This answer is required in order to review your application.

☐ 8a. Did you include a clear explanation of your source of funding as listed under section H. item 8 on page 6 of 7? If not, application will be returned to site.
☐ 8b. Did you include a copy of the initial type of contract or employment agreement that would be offered to the health care professional? If the health care professional will be an employee of the site, a copy of the benefit package that is offered to the employee is requested (i.e., health insurance benefits, hours of paid vacation, hours of sick leave, continuing education leave offered, etc.). If not, application may be delayed or denied.
☐ 8c. Did you include a copy of your most recent audit report? If not, application may be delayed or denied.
☐ 8d. Did you include a copy of your site's recruitment and retention plan? If not, application may be delayed or denied.

☐ Have you responded to section H. item 9 on page 6 of 7 of application? If not, application may be delayed or denied.

☐ Did you complete section H. item 10 on page 6 of 7 and include the signature, email address, and telephone number of the person completing the application?

☐ Additional comments or information may include support letters from local community leaders, health care professionals, or agencies/organizations supporting your recruitment and retention efforts.

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